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Tackling health inequalities through asset-based approaches, co-production and empowerment: ticking consultation boxes or meaningful engagement with diverse, disadvantaged communities?

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Introduction

In a bid to tackle inequalities, policymakers have increasingly embedded concepts such as community ‘empowerment’ and ‘engagement’ into regulations (Commission on Social Determinants of Health (CSDH), 2008; Department of Health (DH), 1999; Popay, 2010). No longer regarded as aspirational and discretionary terms in the policymaking arena, these participatory, agency evoking actions have become inextricably linked to legislations advocating the use of bottom-up, person-centred, co-produced, asset-based approaches (Morgan, Davies and Ziglio, 2010).

Central to asset-based theory, is the belief that continued positive health and social outcomes is achievable when individuals and their communities have the chance and capacity to manage their own futures. From a policy perspective, this means focusing on their positive capacity rather than on individual or collective needs, deficits and problems (Christie, 2011). The approach emphasises the importance of assets, which can be social, environmental, financial, physical or human resources such as education, employment and social networks, local knowledge, skills or passions that inspire people to change their circumstances (Harrison et al, 2004). In other words, assets are ‘collective resources which individuals and communities have at their disposal, which

protect against negative health outcomes and promote health status' (Glasgow Centre for Population Health (GCHP), 2011, p.2).

Asset-based approaches are meant to be enabled by reciprocal relationships between professionals and community members or co-production, which has been called a model of effective collaboration and mutual responsibility (GCPH, 2011) and also a methodology to support 'the identification, collection and measurement of asset-based approaches in the community' (GCPH, 2012, p.6). 'There is no single formula' to replicate process and procedure for co-production (Social Care Institute for Excellence, 2015) – no 'one size fits all' approach (GCPH, 2011, p.11) – and it relies on 'active input' by those who utilise services (GCPH, 2012, p. 11). From an organisational perspective, the aim is to facilitate rather than deliver public services by working with communities thereby breaking down barriers between service providers and users.

Despite its increasing popularity and political influence, the assets movement is frequently under attack for an inability to prove its efficacy. Its triumphs, critics argue, are anecdotal as they fail to unequivocally demonstrate that applying the approach in local communities generates local confidence and self-esteem for individuals and the community alike (Foot and Hopkins, 2010; Friedli, 2013). The overarching censure is that there is no 'published evidence that use of a broad assets based approach can successfully prevent or reverse the main avoidable causes of ill-health' (GCHP, 2011; National Health Service (NHS) Health Scotland, 2012, p. 3).

Notwithstanding this critical assessment, these constructs feature prominently in health board strategies. The aspiration is that their application will lead to a recognition of health assets, which may 'strengthen the ability of individuals and communities to act as co-producers of health rather than simply consumers; reduce demand on limited resources; and facilitate engagement 'with systems in addressing structural causes of injustice and inequalities' (GCPH, 2011, p. 4).

Gaps in extant knowledge, however, include a lack of understanding of how those working in communities – and indeed community members themselves – are engaging with the language of asset-based approaches, co-production, empowerment and engagement, and applying them in real life settings. This paper therefore analyses the views of individuals who work in disadvantaged communities and engage with the most unequal in our society. By applying the CHOICE (Capacity building, Human rights, Organizational sustainability, Institutional accountability, Contribution, and Enabling environment) Framework which aims to link community empowerment and health equity, it critically explores how these stakeholders perceive and are responding to government calls to embrace these participatory approaches and identifies barriers for ‘genuine’ community engagement.

The paper also considers the extent to which practitioners’ interpretations of asset-based theory and community empowerment to address health inequalities are compatible with the views of members of minority ethnic groups living in disadvantaged communities. In so doing, it highlights consistent and conflicting views among practitioners and community members – from the same and different ethnic groups – and considers implications for policy and practice. The critical analysis also uncovers methodological and evaluative issues faced when applying asset-based approaches.

Finally, the paper reflects on contradictory views of health equity being influenced by ‘the choice each of us as individuals is prepared to make’ (Rifkin, 2003, p. 178), as highlighted in the CHOICE framework, and approaches that move beyond a focus on individual choice to account for the structural drivers of inequalities (Kapilashrami, Hill and Meer, 2015,). It suggests that through the lens of human rights and social justice, asset-based approaches may be used to highlight the causes of inequalities by identifying the institutions and powers that create and maintain inequitable circumstances.

The Scottish Approach to Government: Tackling Inequalities through Asset-based Approaches

Despite well-meaning initiatives, disparities in health status are increasing in Scotland where life expectancy has improved more slowly than in the rest of the UK and Europe. Narrowing this inequalities gap is a government priority. Since devolution, the design and delivery of policy and public services has focused on outcomes, prevention, partnership working, improving performance and developing people through asset-based working and co-production (OCSPA, 2015).

An ethnically diverse nation, 4% of Scotland's population belongs to a minority group (Scottish Government (SG), 2016). While this percentage may seem low, patterns of minority ethnic inequalities are extremely diverse and these groups tend to have poorer health than the general population. Differences in socioeconomic status, higher levels of poverty, unemployment and a multifaceted interplay of factors influencing ethnic wellbeing including long-term impacts of stigma, racism, migration, variances in lifestyle, culture and identity as well as poorer access and acceptance of healthcare services, all contribute to health inequalities (Parliamentary Office of Science and Technology, 2007).

A Ministerial Task Force on Health Inequalities met for the first time in November 2012 to address the problem and inequalities is a dominant theme in various policies. One example, is the Scottish Government's Tobacco Control (SGTC) Strategy, which aims to create a tobacco-free generation by 2034 and strongly advocates asset-based approaches as a way to achieve this (SG, 2013). It recognises smoking as one of the principal causes of illness and premature death in Scotland with an estimated 13,000 deaths each year, and the strong correlation between socio-economic status and smoking prevalence (NHS Health Scotland, 2012; ScotPHO, 2011; SG, 2011, 2012).

This research emerged as NHS Greater Glasgow and Clyde (NHSGGC), Scotland's largest health board, moved towards learning, embedding and standardising good practice from new approaches such as co-production and asset-based work with communities. As well as adopting these approaches in practice, a clear focus in the Glasgow Tobacco Strategy (the health board's local

policy to trying to achieve the SGTC target) is the relationship between social determinants of health – or ‘the conditions in which people are born, grow, live, work and age’ (World Health Organization, 2015) – and health inequalities.

NHSGGC was particularly interested in the views of diverse ethnic minority groups in disadvantaged neighbourhoods as it had a paucity of baseline data to inform health service improvements. The researcher was therefore commissioned to gather perceptions of health from Slovakian, Pakistani, Polish and ‘Roma’ community members living in one of Scotland’s most ethnically varied and economically unequal areas where approximately one in five belong to ethnic minorities (Hutchison, 2011). Operationalising ethnicity in these standardised categories raised ethical issues (presented in the Methods and Discussion).

Methods

Research commenced with a six-month ethnography so the researcher could immerse herself in these communities in a bid to understand beliefs and behaviours ‘from a native view’ (Jones, Kriflick and Zanko, 2005; Mertens, 1998). Building on previous work on the Black Minority Ethnic (BME) population in the area which focused on smoking cessation and health inequalities (NHSGGC, 2006), the study also sought to explore the feasibility of engagement and relationship building with community members over a relatively short period. The overarching aims were to (i) gather specific BME groups’ perceptions of a number of pre-identified and emerging health related issues (including tobacco and shisha use; smoking cessation; acceptability of services; alcohol consumption; and addiction), and (ii) to explore how an asset-based approach and co-production could be used to engage with minority ethnic groups.

The researcher contacted members of formal and informal networks and spent time in local neighbourhoods – going to shops, community centres, libraries and shisha cafes for example – and getting to know community members. Ethnography was also conducted at two community events.

A reflexive journal was kept throughout and notes were either taken *in situ* or straight after exchanges (Foley, 2002). Community members (n=69) engaged with the researcher throughout the ethnographic process, but generally expressed a preference for notes to be taken rather than having their voices recorded. This raised ethical issues, which were carefully considered.

For example, it became apparent that the 'Roma' population in the neighbourhood is not homogenous, but comprised of various sub-groups such as the Romanian Roma (RR) and Slovakian Roma. RR community members in particular were not familiar with the concept of 'informed consent' and none of the participants in this study spoke fluent English. The researcher therefore worked closely with social workers and established community groups, who provided translators and opportunities for engagement. The study obtained ethical approval from the University of Stirling's research ethics committee and consent to participate was voluntary. Participants were advised of the nature of the study, received an information sheet with project details and gave written informed consent to take part. Anonymity and confidentiality were guaranteed to all participants.

As community members began to trust the researcher (Flanagan and Hancock, 2010; Tonkiss and Staite, 2012), they shared their views on (i) and introduced her to additional key contacts and representatives from community organisations in the area. Some of these individuals agreed to be interviewed and, through a purposive, snowball sampling technique (Miles and Huberman, 2004; Sullivan et al, 2005), 35 participants shared insights on (ii) through semi-structured, face-to-face interviews exploring how they perceive and practically apply the constructs referenced in policy documents. Seventeen individuals agreed to have their interviews recorded, which were then professionally transcribed. Interviews ranged from 40 – 70 minutes (see Table 1). Detailed notes were taken during the other interviews *in situ*.

Participants were diverse in professional experience and community involvement and engaged with communities for various reasons, for example, as community health practitioners,

volunteers, social workers, community researchers, community advocates or representatives from community organisations (RCO). To protect the anonymity of contributors, 'RCO' or 'practitioner' are used as generic terms for all participants who are (or have been) engaged with these communities in formal or informal capacities.

A topic guide was used in interviews with a series of open-ended questions exploring asset-based approaches, co-production, engagement and empowerment (for example, what does co-production mean to you? How are asset-based approaches being applied in community settings? What barriers or opportunities have you uncovered when applying asset-based approaches in disadvantaged communities?).

Interview data were stored and initially analysed using the qualitative software programme Nvivo and an inductive approach whereby broad-based themes that were strongly linked to the data were identified and coded (Patton, 1990). While interviews were being conducted, the researcher was still in the field as ethnographer so data collection and analysis was not a linear process. This allowed for emergent themes to be fed back into ethnographic settings so community members could respond to the views put forward by those working in the area in an iterative way (Lingard et al, 2008; Pope et al, 2000). Similarly, community members' responses were fed back into the interview topic guide and informed subsequent interviews. For example, when it emerged that some community members felt engagements were 'tokenistic', this was put forward to practitioners as an additional question when exploring barriers to asset-based working: "How would you respond to criticisms that the application of asset-based approaches in disadvantaged communities are 'tokenistic' rather than genuine?").

This approach (where community members and practitioners confirmed or refuted emergent findings) and triangulation (the integration of multiple data sources) added rigour to the study and was deemed to be necessary as the ethnographer was the sole researcher (Creswell and Miller, 2000; Gotlib Conn, 2010).

The following key emergent themes were identified during the inductive analysis: disconnection between policy and practice; tokenism versus genuine engagement; cultural barriers to engagement; co-production and co-creation; local champions; and creative community initiatives (see Box 1 for descriptions). Emergent themes were then analysed deductively using the CHOICE theoretical framework.

The CHOICE framework is used to describe and assess the relationship between empowerment, equity and positive health outcomes (Rifkin, 2003). Drawing on Amartya Sen's work on 'development as freedom' which views coercion and poverty as the results of limitations of opportunities to develop individual capacity (Sen, 1999), CHOICE sees choice as the enabler for people to realise their full potential. It proposes that people's choice is currently limited due to inequity in distribution of resources and opportunity alongside absent or ineffective mechanisms facilitating active engagement in consensual decisions (Rifkin, 2003). As asset-based approaches and co-production, in theory, are meant to address (at least some of) these shortcomings, CHOICE is a useful analytical departure point for this research.

The framework poses a thematic question to structure and guide an analysis for each concept presented by the letter of its acronym. Concepts and accompanying questions are presented in the following sections, along with a critical analysis of whether and/or how they were evident in this research.

Findings

Capacity Building

'Question: Can local people obtain and act upon new skills and/or knowledge to improve their health?' (Rifkin, 2003, p. 172)

According to some individuals working in the neighbourhood, community members will only obtain knowledge to improve their health if practitioners are proactive and '*linked in*' (RCO14) as explained in this comment: '*they [community members] won't come to us, we need to go to them*' (RCO13). The view that practitioners have to be '*sign posters*' (RCO2) may undermine the values of empowerment, co-production and equality – indeed aligning them with deficit models of 'experts knowing best' – if dismissive of community members' cultures, traditions and lived experiences.

This was implicit in other practitioners' responses, which reflected on the processes involved in community capacity building through co-production. According to one practitioner, the proposed starting point for engagement should be an awareness and acceptance of cultural variance, a blank sheet of paper and asking simple questions such as: '*What are they [communities] interested in? What are the gaps in their knowledge? Where do they feel they need support and help?*' (RCO4). The next step, according to another practitioner, would be to develop projects with community members '*so that you know they can fill those gaps*' (RCO7).

Getting access to community members in the first place, however, was highlighted by most practitioners as a challenging exercise due to an '*over consulting phenomenon*' (RCO12); expectation of incentives such as grocery vouchers, '*exchange of money or a token*' (RCO5), food or '*some kind of reward*' (RCO6); translators who '*don't give correct information to their clients*' (RCO7); and other language, literacy and numeracy barriers (ethnographic observations, community event).

Several Polish community members, for example, told the researcher that many Polish people are not fluent in English so sharing health information by word-of-mouth is preferable. Others were doubtful that this approach would work as they believed Poles do want other people to know their problems – you speak to your family and friends not to strangers (ethnographic observations, local shop).

This view was echoed by some RR community members, who perceived privacy and keeping to your own family as important to stop gossiping in the community. Practitioners working with this ethnic group reflected on its heterogeneity and how, *'if you're not associated with that [specific] clan'*, there will be limited engagement (RCO15). Some Pakistani community members said they trust only in good friends and God, but not family as they too feared causing embarrassments perpetuated through gossiping (ethnographic observations, community centre and shisha café).

Imbalances of power and misinformation were flagged as obstacles to capacity building by some practitioners as *'there's a power struggle in these new communities' – 'the young ones are kicking up their heels. Interpreters are not really real assets. They may be intimidated by a situation and misinformation goes on'* (RCO2).

Other practitioners raised the importance of building capacity to improve community members' health through *'dynamic'*, trusted local champions or *'informal leaders'* with expertise (RCO10). Described as *'a layer of kind of civic leaders'* (RCO15), these locals were seen by some practitioners as instrumental in reaching community members when confidentiality was an issue (RCO12) – a belief echoed by some community members. For example, one spoke about the benefits of working with Polish shopkeepers, who own small shops in the area when trying to connect with Poles (ethnographic observations, community centre).

Other practitioners, on the contrary, suggested that some *'self-appointed'* local champions or *'wheeler dealers'* (RCO2) and translators are not entirely altruistic and pose barriers to the flow of knowledge and capacity building by acting as community gatekeepers. This became evident during the ethnographic process when the researcher was told she could not just arrive and engage as there are codes and procedures to follow. One community member explained that this was not about trying to put up barriers, but what community members simply have to do (ethnographic observations, community event).

Several practitioners highlighted the '*wariness*' of engagement as community members have '*been researched to death*', which '*hasn't built trust in the communities*' (RCO1). A few pointed out that findings are not communicated to community members so they '*they don't see how the results of the research are used to change their lives for the better and it's all very detached*' (RCO6).

Human rights

'Question: By exercising their rights, can the poor influence the circumstances that produce their poverty?' (Rifkin, 2003, p. 173).

Exercising human rights was not explicitly raised by practitioners or community members as a way of influencing communities' circumstances to improve health and wellbeing, even though the language of human rights is evident in existing public policies and strategies promoting person-centred care, co-production, empowerment and asset-based approaches.

Advocated as a way of protecting the dignity of the most marginalised citizens, a human rights approach is also viewed as a way to drive high-quality health and social care with outcomes focused on what matters most to communities themselves (ALLIANCE, 2013). It emphasises the right that everyone has to participate in the decisions which affect them, but in this research there was some indication that community members were resistant to engaging in co-produced initiatives even if they were designed to be in their best interest. One practitioner described this as '*passive resistance*' (RCO5) and explained how organisations need to persevere as community members do not always respond to communications.

Non-discrimination, another key facet of a human rights approach, was implicit in some community members' responses that suggested individuals from minority ethnic groups do not engage as they may not always feel welcomed in certain organisations or community projects due to perceived racism. One community member described how challenging it was to be '*one of the first black people*' in a programme '*because we thought this was a white club*' (RCO15). This

sentiment was expressed by an individual from a different minority ethnic group who objected to the 'BME' categorisation as all black people are not the same and should not be called the same (ethnographic observation, community event).

Organisational stability

'Question: Can organizations be developed and maintained to ensure sustainability of health gains for the poor?' (Rifkin, 2003, p. 174).

Several individuals who work with communities said that while asset-based approaches are being advocated by policymakers and health bodies to address health inequalities – described by one practitioner as *'fashion at the minute'* (RCO9) – there is a disconnection between policy and practice as approaches are not being properly applied. Practitioners suggested that health boards and community organisations need to train their staff in the application of these approaches; support them to work in this participatory way; promote strong professional leadership; and have clear organisational values and cultures that are aligned with principles of empowerment.

Some practitioners added that sustainable community engagement has much to do with organisations and their leaders – the *'particular traits and characteristics of whoever is trying to engage with communities'* (RCO16) – and how adaptable they are to community members' needs. While some people working in communities commented on the *'favourable policy landscape'* (RCO2) promoting the sustainability of health gains for the poor and current commitment to addressing inequalities, organisational stability could not be guaranteed if new policies or governments replaced existing ones.

Institutional accountability

'Question: Can mechanisms be developed to ensure resource allocation and decisions benefit those most in need?' (Rifkin, 2003, p. 175).

A lack of sustained funding was identified as a significant barrier to beneficial engagement with communities by several practitioners. As RCO said: *'you try not to be this parachute effect and then the funding goes and you have to develop and start all over again'* (RCO17). Some practitioners voiced an acceptance of dwindling resources – the inevitability of having to leave a community once money runs out – but were hopeful that there would still be some gains for those most in need and that meaningful relationships would be established.

Indeed, building and maintaining relationships was emphasised as integral to the process of co-production. The view expressed by most representatives working in communities was that sustained, solid connections with community members was the key mechanism needed for them to have ownership of ongoing projects and decision making, and the agency to generate new community initiatives. The ideal, according to some practitioners, *'is when the idea for a research project emerges with them'* and *'you are not having this point where you are having to get in contact with them [community members] to ask them to help you with recruitment'* (RCO2).

Other representatives from community organisations suggested that *'there is money sloshing around for workers and for projects'* (RCO11) particularly with minority ethnic groups so vested interests, *'inherent power'* (RCO15) and engagement with some community members and organisations need to be carefully balanced and monitored.

Contribution

'Question: How does the contribution of a programme's intended beneficiaries reflect its development?' (Rifkin, 2003, p. 176).

Several representatives from community organisations noted that genuine engagement and co-production should start without an agenda. They stressed the importance of abandoning preconceived ideas of what an organisation wants to get out of the programme, and how it wants to help community members. Instead, they said that organisations *'have to respond to what people*

are saying are the priorities and assets' (RCO1). One practitioner added that programmes need to be developed on the basis of *'what people care about and what matters'* so for organisations it is *'about changing the position, changing the mind set and changing culture'* (RCO11).

According to some RCOs, there is also a misconception about asset-based working – that you can only apply it entirely or not at all. They emphasised that an organisation *'can be asset-based working to some degree'* (RCO3). This calls for a balance between developing programmes on the basis of intended beneficiaries' strengths, capacities and capabilities, but also an awareness of their needs, possible treatments, deficits and problems. One interviewee added that *'a blanket approach'* of engagement would not work as there needs to be *'autonomy in local messages specific to groups'* (RCO8), while all practitioners agreed that it was *'hard to make generalised statements about how to engage with communities'* (RCO5). Developing innovative programmes around sport, music, media, food, the arts and with the youth was highlighted by several community members and those working in the community as a key way to engage with community members and direct them to particular services.

Enabling environment

'Question: What is the contribution of the existing environment to pursuing equity and empowerment for health improvements?' (Rifkin, 2003, p. 176).

While there was a general acceptance that the language of asset-based approaches and co-production is now a part of the existing environment and intuitively seen by most practitioners as *'a good way of working'* (RCO13) in health improvement, several said that organisations *'are just not sure how to do it'* (RCO9). They also noted that researchers and health practitioners are not always welcomed by community members particularly when they do not report findings back to communities or engage with them on an ongoing basis. Several RCOs said there is still the perception

that organisations are only engaging with community members, because they need to *'tick a consultation box'* and *'they don't really care about changing the lives of the Roma'* (RCO12).

Efforts to engage with community members using asset-based approaches were considered by some practitioners to be somewhat superficial: *'it doesn't feel like a real proper exchange... I don't think it's meaningful'* (RCO17). Health bodies were also criticised by some community workers for neglecting to act on research recommendations that stem from the views of marginalised communities. Instead, according to one practitioner, organisations *'drip research findings into professional discourses'* in *'a very linear way'* (RCO3). This was considered contrary to asset-based practice where the end of an inquiry in a community *'is not the end of the process, but the beginning'* (RCO3). One practitioner added that communities *'have to think they've had the idea themselves to actually change'* (RCO5).

Several practitioners stressed that a balance needs to be redressed in the way services are currently delivered and there are significant challenges to working in this way for health and care services due to *'organisational cultures'* (RCO10); *'traditional ways that services are delivered'* (RCO2); *'professional boundaries'* (RCO3); and *'the skills and values of the individual members of staff within those teams'* (RCO15).

Discussion of the implications of the research

The range of views gathered throughout this research underscores the perceived gap between policy prose and 'real practice on the ground' when applying asset-based approaches to address health inequalities. The position that policymakers are using these approaches as rhetorical devices and practitioners failing to apply them 'properly' was prominent. While the pretext for the latter was attributed to a lack of understanding of the theories and their practical applications, the former was linked to the belief that asset-based approaches and co-production are merely fashionable

policy terms driven by organisational and political self-interest rather than genuine concern for the wellbeing of the most unequal in our society.

The need for organisations to achieve pre-determined, short-term goals outlined in strategy documents and local action plans is, at least to some extent, at odds with the methodological applications and indeed challenges faced when using approaches that are fundamentally underpinned by building and sustaining long-term relationships. During the research, it became apparent that without trust, there could be limited meaningful engagement – and trust needed to be cultivated over time rather than by dipping in and out of community settings when organisational objectives needed to be achieved. It also became evident that sustained engagement could enable a deep-seated understanding of diverse communities' cultural specificities in local contexts and what community members actually want from health services and programmes.

For some practitioners, the 'parachute effect' was a matter of practicalities: budget and funding cuts and lack of resources. For others, it was about individual and organisational cultures and values being misaligned and discordant with the principles of asset-based working. While staff training and strong leadership to facilitate a cultural shift and acceptance of these approaches within organisations were proposed as potential pathways to address these issues, it became evident that these efforts may be somewhat futile if community members still believe engagement to be 'tokenistic' – an increasingly important issue as legislation demands community engagement rather than merely recommending it. This shift from 'want to engage' to 'need to engage' in order to address health inequalities is resulting in communities being constantly bombarded by researchers, practitioners and policymakers. Criticisms that these stakeholders are saying they are using asset-approaches and co-production when (according to several research participants) they are not, are also emerging.

This raises questions of 'choice'. To what extent are disadvantaged community members choosing to be co-producers of health? Are they opting to take part in community initiatives that

are meant to enable them to realise their full potential? Are they being afforded sufficient resources and opportunities to improve their life circumstances in a bid to tackle inequalities? As a critical analysis of findings through the CHOICE framework has highlighted, these are barriers to achieving positive health outcomes and equity through empowerment approaches that still need to be overcome if asset-based approaches are deemed to be successfully applied.

However, it is encouraging that within the relatively short time of six months it was feasible to engage with community members considered to be 'hard-to-reach', either directly or through community organisations or local champions. In the field, community members openly shared information about the realities of their lives adding to the paucity of baseline data on their perceptions of health – this despite the literature suggesting that gaining access to and obtaining rich insights into the views of individuals within these communities can be complex and challenging as distrust and stigma may be testing barriers (Tonkiss and Staite, 2012; Flanagan and Hancock, 2010). Evidently, practitioners and researchers also need to recognise differences and similarities between community members of minority ethnic groups so caution is needed when using comparative analyses in inequalities research and programmes. Indeed, 'there are real concerns that poor research [on ethnic inequalities] may do more harm than good' by stigmatising or pathologising certain groups or treating them as fixed ethnic categories (Salway et al, 2009, p. 4).

Implicit in several community members' responses were social justice affairs such as non-discrimination and (opposition to) coercive participation suggesting that human rights could be foregrounded in interactive, bottom-up, community-led programmes with a focus on arts, media, food, music, sport and the youth. Through creative and non-threatening mediums, community members could challenge institutions and powers that create and maintain inequitable circumstances (see Clift, Camic and Daykin, 2010 for examples) and take ownership of projects that could lead to more positive health outcomes on moderate budgets (Stead, Arnott and Dempsey, 2013). This could help bridge the gap between top-down and bottom-up approaches to health policy

and practice and critically examine the dichotomous view that asset-based approaches cannot be used to challenge the structural causes of inequalities and are abstracted from social injustice (Friedli, 2015).

While a useful departure point for analysis, the CHOICE framework does not provide a mechanism for evidencing the relationship between inequalities, empowerment and health outcomes. Indeed, its author emphasises the need to develop an assessment tool with a set of core indicators that can be applied at baseline in communities to test the connection between empowerment, equity and its impact on health outcomes. This is especially needed to capture unconventional, participatory engagement activities in a rigorous and systematic way if policymakers and practitioners continue to endorse asset-based approaches and related methodologies and constructs (Hill et al, 2010). Careful consideration needs to be given to how 'soft measures', such as relationship building through innovative community events and disseminating health messages through word-of-mouth as a by-product or arts, media or sporting events, can and should be linked back to targets and health improvement performance measures. These in turn, would need to be systematically fed upstream to policymakers to bridge the gap between policy, practice and circumstantial realities for the most disadvantaged in our society.

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